Comments on Selection of State Essential Health Benefits Benchmark Plan

General Comments

The American Heart Association appreciates the opportunity to provide comments on Illinois' selection of an Essential Health Benefits (EHB) benchmark plan. We view the choosing of the EHB benchmark as among the most important decisions for states and their citizens with cardiovascular disease when implementing the Affordable Care Act (ACA).

Adequate, comprehensive insurance is important to patients with heart disease, stroke, and other cardiovascular disease (CVD). Patients with heart disease, stroke, or other CVD often require a wide range of services, including inpatient hospital care, primary and specialty care, emergency care, pharmaceuticals, rehabilitative and habilitative services, mental health care, and skilled nursing and home health care, among others. Since consumers don't always know what services they will need prior to choosing an insurance policy, it's important that the coverage available to them be comprehensive and not include unreasonable limits on specific services.

More than 60 percent of all bankruptcies in 2007 were a result of illness and medical bills, and CVD was the leading cause of medical bankruptcy. Notably, nearly 80 percent of those who filed for medical bankruptcy had insurance coverage. In addition, according to a 2009 survey, more than half of all CVD patients – and 52 percent of CVD patients with insurance coverage – reported difficulty paying for prescription drugs or other medical care in recent years. These patients are more likely to delay or forego needed health care.

The AHA also recognizes that in choosing an EHB benchmark care should be taken to balance the need for patient access to the care they need with the assurance that the coverage is affordable.

Coverage of Preventive Services, including Tobacco Cessation

With respect to preventive services, Section 2713 of the ACA requires all private insurance plans except "grandfathered" plans to cover designated preventive services, including services receiving an A or B recommendation from the U.S. Preventive Services Task Force, without cost sharing. The Department of Health and Human Services clarified in its Frequently Asked Questions document of February 17, 2012 that these preventive services are part of the EHB.

As part of the obligation for the EHB package to include preventive services, we believe it is very important for the state's chosen benchmark to adequately cover a range of services that can help reduce the toll that heart disease and stroke take on our state. If these services aren't covered by the benchmark the state chooses (or it isn't clear what the scope and limits on coverage of preventive services are), the state should supplement the EHB package to include them.

With respect to tobacco cessation services specifically, we urge you to clarify the scope of services that will be required to be covered under the EHB package to ensure that comprehensive services are available. Specifically, while the chart indicates that tobacco cessation drugs and a smoking cessation program are both covered, it's not clear whether OTC cessation products are covered or what the smoking cessation program entails. Nearly one-third of the estimated 443,000 deaths each year that are caused by smoking-related illnesses are CVD- related. Quitting tobacco use leads to increased employee productivity, less disability and chronic disease, and less medical

expenditures. Increasing the number of successful attempts to stop tobacco use will have an important effect on health and health care costs.

Tobacco users vary in what tobacco products they use, how much, how often, and in what coexisting medical conditions they may have. When quitting, they need access to a range of treatments, both medication and counseling, to find the most effective tools that work for them. The covered benefit should include all over the counter and prescription medications approved by FDA (including combination use) and multiple face-to-face counseling sessions conducted by a qualified health professional. Several attempts are usually necessary to successfully quit, and the frequency and duration of treatments should not be limited. Limiting the benefit with preauthorization requirements or other unreasonable limits deters people from using preventive services.

Coverage of Habilitative and Rehabilitative Services

Access to appropriate habilitative and rehabilitative therapy is a critical element of care that minimizes disability and promotes the productivity of patients with many different conditions. This issue is particularly important to stroke patients, both adults and children.

As a starting point, the AHA/ASA supports the definition of habilitation services that has been developed by the National Association of Insurance Commissioners (NAIC)[1], and we recommend that the state adopt this definition. We also are pleased to see the inclusion of required habilitative services offered at or above parity with rehabilitative services, though the limits being placed on habilitative care are unclear.

It is also unclear that the proposed benchmarks sufficiently cover cardiac rehabilitation services following a heart attack, coronary artery bypass surgery, or other cardiac events. Research has shown that participating in cardiac rehabilitation can reduce cardiac mortality by as much as 31% and it has also proven beneficial in preventing a second heart attack. Despite the clear benefits of cardiac rehabilitation, the use of such programs remains dismally low. Of eligible patients, only 14% to 35% of heart attack survivors and 31% of patients after coronary bypass surgery participate, and lack of insurance coverage or inadequate insurance coverage is frequently cited by patients as a reason for not participating. We urge you to clarify that cardiac rehabilitation is required to be covered under the EHB benchmark under the rehabilitative and habilitative services category and to ensure that the scope of coverage of this benefit is adequate (a full course of cardiac rehabilitation is generally 36 sessions in 12 weeks).

Medically Necessary Ambulance Transport

While the inclusion of coverage for air and ground ambulance service is welcome in the plans, it is worth reinforcing that the standard should be all “medically necessary” air and ground ambulance transportation, and not a potentially more narrowly define “emergency” air and ground ambulance transport. The distinction is important to ensure that the inter-hospital transport of patients with emergent conditions be covered, as patients suffering for example from STEMI heart attacks or strokes may currently be initially transported via a municipal ambulance to an initial hospital only to be quickly “dripped and shipped” to a STEMI receiving center or primary stroke center. This secondary ambulance transport is medically necessary for the patient, and should not be excluded from coverage.

[1] The NAIC defined “Habilitation Services” as “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”

Benefit Design Flexibility

In its proposed regulatory approach to defining the EHB package, HHS indicated that it intends to grant insurers "benefit design flexibility." This flexibility would allow insurers to adjust both the scope and limits of benefits covered in a way that is "substantially equal" to the benefits of the benchmark plan. Insurers could do so by making substitutions within and, potentially, across benefit categories so long as substitutions are actuarially equivalent. In the event that HHS allows insurers to make such substitutions in future rulemaking, we strongly recommend that our state use its authority to 1) ban or restrict the use of substitutions both within and among benefit categories; and 2) subject benefit substitutions to a heightened level of regulatory scrutiny to ensure that any substitutions do not result in the elimination or limitation of important services or benefits.

The EHB standard is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully-insured plans in the individual and small group insurance markets so that consumers can make an apples-to-apples comparison of plan options and to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal for "benefit design flexibility" would undermine these goals, regardless of whether variation is allowed within benefit categories or across benefit categories.

We are concerned that these "substitutions" could be used to conduct "back-door underwriting" by encouraging the enrollment of healthy enrollees at the expense of less healthy consumers who may need a more comprehensive benefit package. While we believe some innovation in benefit design can help consumers by, for example, reducing or eliminating cost-sharing for high value services, we are concerned that allowing substitution of critical benefits will enable insurers to structure their benefits in ways that discriminate against high-risk consumers, such as those with chronic conditions and disabilities. For example, if such substitutions are permitted, an insurer could choose to dramatically reduce its benefits for rehabilitative and habilitative services and devices—which are disproportionately used by those with disabilities—but increase its benefits for other services that may be less likely to be utilized by the consumer and, thus, less costly to the insurer. Even if actuarially equivalent, allowing insurers to make substitutions could discriminate against high-risk consumers—precisely the type of practice the ACA set out to eliminate. For these reasons, we object to the use of substitutions that will degrade the value of a minimum standard of mandated benefits; hinder consumer understanding and the ability to make apples-to-apples comparisons among plans; and enable insurers to design plans that fail to provide essential services for some enrollees.

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